

Collaborative Care Model for Bipolar Depression and Schizophrenia in the Institution

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Bipolar Disorder and Schizophrenia

- Chronic conditions
- Often debilitating with acute crises
- Successful treatment looks beyond the acute crisis—The Band-Aid—towards chronic care
- Addressing issues beyond the basic medical decisions is essential to recovery

Collaborative Care Model

- Care coordination and case management
 - Addresses social difficulties frequently associated with these conditions
 - Eases navigation of complex systems
- Treatment with active monitoring
 - Use of scales
- Specialty care available
 - Referral when a lack of improvement

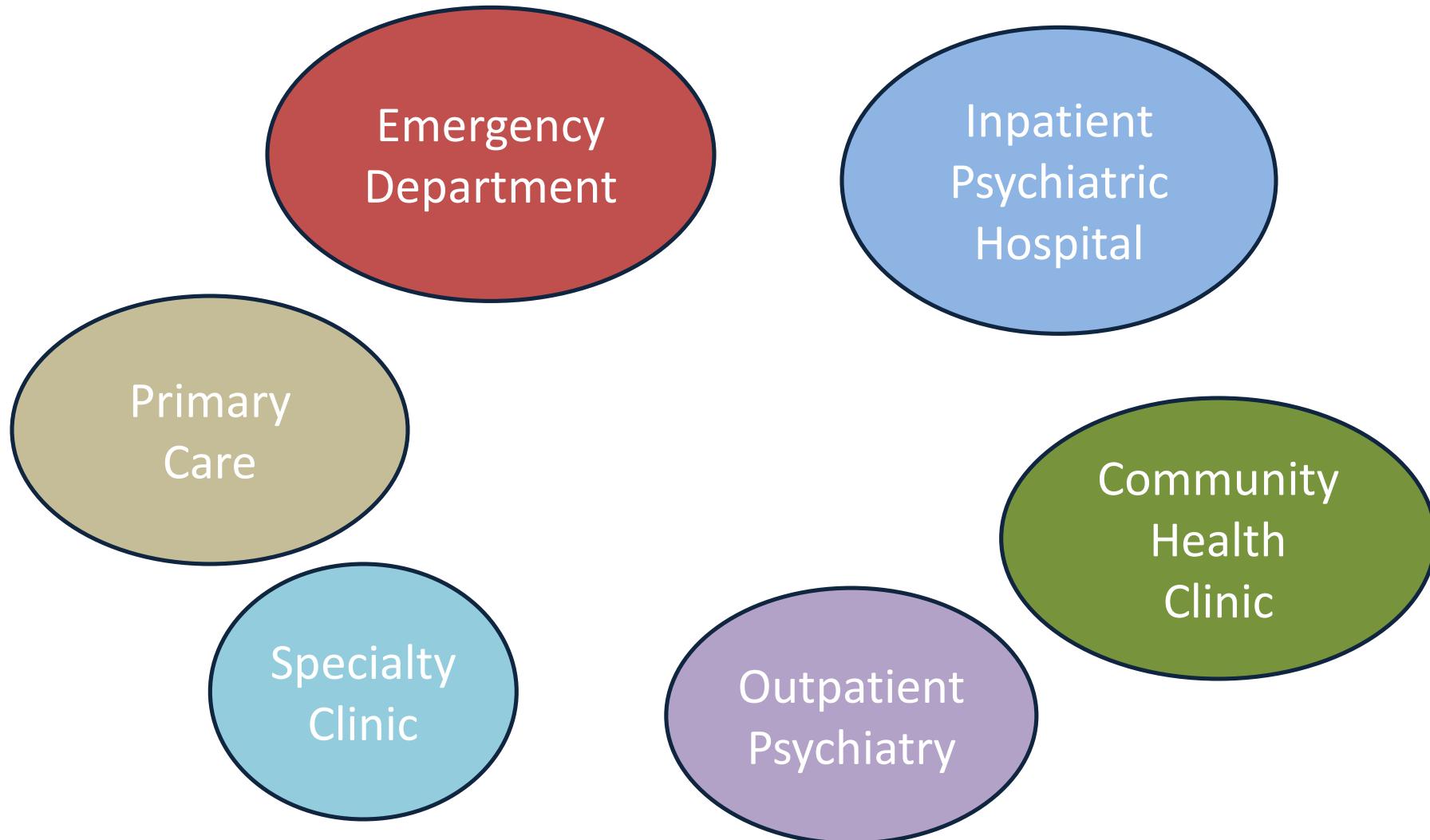
Traditional Model of Care

- Focused on management of acute illness
- Fragmented care
 - Patients seek care across many systems
 - Providers do not always know when someone else is seeing a patient
- Limited time and resources for care coordination

Goals

- Review the settings of care from a provider perspective
- Identify communication challenges in the traditional care model
- Describe strategies to facilitate communication and move towards a collaborative care model

Settings of Care



Emergency Department

- Often the initial point of care
 - Patients and families recognize something is wrong, but do not know where to turn
- Safety Net
 - People do not know where to turn
- Varying levels of expertise
 - Emergency Medicine physician
 - Psychiatrist
 - Social Worker

Emergency Department

- High volume and high acuity
- Limited knowledge of and limited relationships with patients
 - Unknown history
 - Unknown coping styles
- Limited referral resources
 - Hospitalization
 - Partial Hospitalization
 - Outpatient care

Emergency Department

- Focused care
 - Diagnosis
 - Treatment/Disposition
- Safety trumps all
- PRN communication
 - Evaluation and decision making is a rapid process by necessity
 - Providers may or may not be called as clinically indicated

Emergency Department

- Challenges to communication in this treatment setting
 - Volume of patients and the pace
 - Availability of outpatient providers
 - Visits often occur after hours
 - Many providers do not have a reliable way to contact them after hours
 - Patients do not always know the names or numbers of providers

Emergency Department

- What is gained when care is coordinated?
 - The longitudinal perspective
 - Pre-existing management plans
 - The opportunity for close follow-up
 - The opportunity for coordinated inpatient admissions

Inpatient Psychiatric Hospitalization

- Locked units that may be general (any diagnosis) or specialized units
- May or may not be a part of a hospital system
 - Outpatient providers are often not a part of the same hospital system
- Electronic medical records may or may not be visible to other parts of the system
 - Privacy concerns may lead to restricted notes

Inpatient Psychiatric Hospitalization

- Acute care focused on rapid stabilization and step down
 - Hospital Length of Stay is closely monitored
 - Pressure for shorter lengths of stays
- Interventions designed for rapid effect
 - Medication and non-medication
- Multidisciplinary team
 - Physician, case management, social work, and nursing

Inpatient Psychiatric Hospitalization

- The medical records:
 - Medications
 - Dose adjustment
 - Additions
 - Discontinuations
 - Critical Events
 - Restraints
 - Suicide attempts
- Coordinated aftercare
 - May or may not involve physician contact

Partial Hospital

- Outside of the hospital system
- 6-8 hours of treatment a day
 - Most commonly occur during working hours
- Patients are not admitted to the hospital and stay at home
 - Increased freedom
 - Begin to confront stressors not present in hospital
- Types of interventions
 - Group therapy (primary treatment modality)
 - Individual Therapy
 - Medication Adjustment

- Psychiatrist
 - Overseeing care
 - Often limited contact with patients
- Psychologists
 - Performing individual work
 - Leading groups
- Social Workers
 - May perform similar tasks as psychologists
 - Case management and aftercare

- Programs typically last 2 weeks
- Often used as aftercare/step-down from inpatient hospitalization
- Can be used instead of hospitalization
 - If safety is not an issue
- Communication with key outpatient providers typically occurs, often triggered by acute events
 - PCP may not be aware of partial admission
- Patients may not attend

- Physician who oversees patient's health and manages many conditions
 - Average U.S. PCP panel size is 2300

Alexander GC, Kurlander J, Wynia MK. Physicians in retainer ("concierge") practice. A national survey of physician, patient, and practice characteristics. J Gen Intern Med. 2005;20(12):1079–1083

- Responsible for coordination of care amongst specialists
- Limited familiarity with and training in mental health issues

- Significant disparities are present in health care outcomes
 - Testing and monitoring
 - Prescribing
- Significant physical health consequences of many psychiatric medications
 - Metabolic syndrome
 - Long term side effects
- Varying degrees of coordination occur

- Coordinating care for all body systems
 - Each one has significant needs
- Small interventions requiring short amounts of time are amplified by patient numbers
 - 3-5 minutes extra per patient can be 2 or more hours by the end of the day
- Medical record integration is helpful if providers are within the same system

Hospital System

- Presence of primary care and specialists in one system
 - Opportunity for connected care
- Large systems with multiple sites
 - May have limited in person interaction between specialties
- Potential for integrated medical record
 - This is passive communication and requires someone to look for it
- Improved ability to refer
- Good support services

Community Health Clinic

- Often a part of a hospital system
 - Unified, visible electronic medical record
- On site mental health and primary care
 - Psychopharmacology
 - Psychotherapy
- Opportunity for well-integrated care
 - Repeated contacts with the same providers
- Opportunity for education between specialists and PCPs

Specialty Clinic

- Clinicians who are expert in bipolar disorder or Schizophrenia
 - Increased awareness of best practices
- Often involved in research
 - Protocols may provide additional support
- Integrated psychology staff can provide psychotherapy
 - Improved communication between providers
 - Opportunities for discussion about challenging cases

Moving towards Collaborative Care

- Insurance
 - Massachusetts and Federal laws
 - Improvement in coverage of previously uncovered coordination services
- Electronic health record
 - Central repository for critical patient information
 - Reminders
 - Secure communications
- Increasing access to providers
 - Telepsychiatry

Collaborative Care at MGH

- Collaborative Care
 - Team consisting of a behavioral health specialist and supervising clinicians
 - Provide support to primary care physicians for straightforward psychiatric conditions
 - Services offered:
 - eConsults
 - iCBT
 - Traditional Collaborative Care

Collaborative Care at MGH

- Team-based Outpatient Psychiatry (TOP)
 - Designed to provide a broader range of treatments
 - Team consisting of a social worker, psychiatrist, nurse practitioner, psychologist, and medical assistant
 - Services offered:
 - Timely evaluations
 - Short course of psychotherapy
 - Medication management
 - Case management
 - Assistance with referrals

- Continued changes to reimbursement
- Identification of opportunities for support staff to improve provider communications
- Virtual meetings triggered by critical patient events
- Electronic medical record prompts for communication with multiple providers ordering tests or prescribing
- Electronic reminders for communication